Insurance and Banking Committee 1

Amendment No. 3 to HB2303

McManus
Signature of Sponsor

AMEND Senate Bill No. 2427 House Bill No. 2303*

by deleting all language after the caption and by substituting instead the following:

WHEREAS, the stability of the health care delivery system is threatened and patient access to care is jeopardized if there is a lack of predictability and accountability concerning allowed amounts from and reimbursement mechanisms utilized by third-party payers; and

WHEREAS, third-party payers utilize a complex system of claim adjudication edits, rules, methodologies, and processes to determine provider reimbursement and are able to change any of these components and correspondingly reduce provider reimbursement; and

WHEREAS, to help ensure the financial stability of health care organizations, health care providers must be able to predict the amount of revenue that they can reasonably expect to receive from services delivered to subscribers of health benefit plans underwritten or administered by third-party payers; and

WHEREAS, in order to make such predictions, health care providers must be given sufficient detail, prior to entering into, during, and upon renewal of a contract with a third-party payer, to understand fully the rules and logic utilized by the third-party payer that will ultimately determine the maximum amount that the provider will be permitted to receive for each item, or service, or combination of services they will be or are obligated to provide under the contract; and

WHEREAS, to ensure predictability, it is also essential that medical claim adjudication edits, rules, methodologies, and processes used to determine provider reimbursement amounts remain constant for specific periods of time and not be subject to unilateral changes not otherwise mandated by law; now, therefore,

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BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following new part:

56-7-3401. This part shall be known and may be cited as the "Health Care Provider Stability Act."

56-7-3402. As used in this part, unless the context otherwise requires:

(1) "Health care provider" has the same meaning as defined in § 56-7-3301;

(2) "Material change":

(A) Means a change in fees or payment methodologies that a reasonable person would attach importance to in determining the action to be taken upon the change;

(B) Includes:

(i) A change to:

(a) Fee schedules previously agreed upon by the third-party payer and a health care provider; or

(b) The third-party payer's internal coding guidelines, edits, and payment rules, including, but not limited to, multiple procedure payment reduction rules, claim payment procedures, or any other elements that the

third-party payer utilizes to determine payment or reimbursement amounts; or

(ii) Any other means that a third-party payer or a health care provider may utilize to adjust a rate for payment of items or services previously agreed upon pursuant to a contract or fee schedule between the third-party payer and the health care provider; and

(C) Does not include:

(i) Any revision to an enrollee's benefit package;

(ii) Any process or program the third-party payer utilizes to determine the medical necessity of a health care item or service, including, but not limited to, utilization review procedures and prior authorization determinations;

(iii) Any process or program the third-party payer utilizes to investigate and address fraud and abuse with regard to the health care provider that the third-party payer has contracted with to provide items or services to the third-party payer's beneficiaries;

(iv) A change in Current Procedural Terminology (CPT) codes pursuant to the release of CPT coding guidelines from the American Medical Association and the federal centers for medicare and medicaid services, as applicable;

(v) A change in internal coding guidelines pursuant to a development in evidence-based medicine guidelines issued by a source other than the third-party payer or the health care provider that does not adjust the rate of payment previously agreed upon by the third-party payer and the health care provider in a contract;

(vi) Any change in the average wholesale price for immunizations, vaccines, injectables, and other drugs or solutions; or

(vii) Any change or addition in items or services to be provided by the health care provider and paid for by the third-party payer that does not adjust the rate of payment for items or services previously agreed upon by the third-party payer and the health care provider; and

(3) "Third-party payer" means a health insurer, third-party administrator, or other person that is obligated pursuant to health insurance coverage or a health benefits plan to pay for covered health care services rendered to beneficiaries.

56-7-3403.

(a) If a third-party payer or health care provider desires to effect any material changes that adjust a previously agreed upon rate of payment for which a health care provider is paid for providing items or services, the third-party payer or health care provider must effect all material changes at one (1) time during a calendar year and is prohibited from effecting a subsequent material change for at least twelve (12) months from the date of any prior material change.

(b) The third-party payer or health care provider is required to send written notice of a material change to the other party sixty (60) days prior to the effective date of the material change.

56-7-3404. A third-party payer or health care provider may maintain an individual or class action as the sole remedy to enforce this part. The court may also award attorneys' fees and costs to the prevailing party. Venue for such actions shall be in the

county in which the complaining party's principal place of business is located in this state.

56-7-3405. None of the requirements of this part may be waived by contract, and any such purported waiver is void.

56-7-3406. Nothing in this part obviates a third-party payer's obligation to comply with any and all legal requirements to which the payer must comply with respect to participating or non-participating health care providers.

56-7-3407. Nothing in this part shall apply to any contract between a third-party payer and a health care provider for items or services to be provided for individuals covered by the federal medicare program, including medicare advantage, medicare select, medicare supplement, medicare and medicaid enrollees (MME), medicare dual special needs, and medicare private fee for service; state, local government, or local education insurance plans established under title 8, chapter 27; the TennCare or Medicaid waiver program established under title 71, chapter 5; any other health plan managed by the health care finance and administration division of the department of finance and administration; or any entity that is subject to delinquency proceedings and for which the commissioner of commerce and insurance has been appointed receiver or any entity placed under administrative supervision by order of the commissioner pursuant to title 56, chapter 9.

56-7-3408. Nothing contained in this part shall be construed or interpreted as prohibiting either a third-party payer or a health care provider from terminating a contract for the provision and payment of health care items or services in accordance with mutually agreed upon terms in the contract.

SECTION 2. If any provision of this act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this act, and to this end the provisions of this act are hereby declared severable.

SECTION 3. This act shall take effect upon becoming a law, the public welfare requiring it, and shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in this state on or after October 1, 2014.